North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services

2501 Mail Services Center
Raleigh NC 27699-2501

801 Ruggles Drive
Raleigh, NC 27603

Thank you for your interest in becoming a Physician Provider with the North Carolina Medicaid Program. In order for us to complete the enrollment process, please submit the following:

- Physician Provider Enrollment Application
- North Carolina Division of Medical Assistance Medicaid Participation Agreement – All applicants must indicate they have read, understood and agreed to the rules and regulations governing Medicaid by signing and dating the NC Medicaid Participation Agreement. Original signatures required. Agreements can not be altered. Applications with strike outs or correction fluid will not be accepted.
- National Provider Identifier (NPI) and Taxonomy information is required.
- A copy of your National Plan and Provider Enumeration System (NPPES) letter must accompany the application.
- Electronic Claims Submission (ECS) Agreement – all applicants who wish to submit claims electronically must read, sign and date the ECS agreement.
- Provider Certification for Signature on File (if desired).
- W-9. Please reference complete instructions which have been supplied by the IRS. **A copy of your EIN Letter must accompany the application**.
- Articles of Incorporation if applying for a group application.
- Copy of current license.

Providers are requested to include on their application the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information. Incomplete or incorrectly completed enrollment applications **will be returned** with a letter outlining the corrections needed.

Providers are assigned a provider number and are notified by mail once the enrollment process has been completed. Please do not submit claims for any services until you have received notification of your provider number, and its effective date. Billing information and medical coverage polices are available on DMA's website at http://www.ncdhhs.gov/dma/prov.htm.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact a Physician Provider Enrollment Specialist at 919-855-4050. We are also on the Web at http://www.ncdhhs.gov/dma/.

North Carolina
Department of Health and Human Services
Division of Medical Assistance

Medicaid Provider Enrollment Application
For
Individual
Physicians, Chiropractors, Optometrists, Podiatrists, Osteopaths and Dentists

Type or print all information in blue or black ink:

Applicant's Name: _____Title_____

Applicant's Telephone Number: (_____) _____

Area Code

Contact Person's Name: _____Title_____

Contact Person's Telephone Number: (_____) _____

Area Code

IMPORTANT INFORMATION

- **Return completed application and agreement to:**
  DMA Provider Services
  2501 Mail Service Center
  Raleigh, NC 27699-2501
- **Retain a copy of application and agreement for your file.**
- **Ensure you have the most current application and agreement. Visit our website at http://www.dhhs.state.nc.us/dma.**
- **Enroll as a Medicaid Managed Care / Carolina ACCESS Primary Care Provider at http://www.dhhs.state.nc.us/dma/caenroll.htm.**
- **Complete a separate application for an individual and group number.**
- **Contact DMA Provider Services at 919-855-4050 for any questions.**

Out-of–State Providers

Out-of-State physicians and dentists beyond the 40-mile border of North Carolina must complete a different application to enroll with the North Carolina Medicaid program in order to submit claims for reimbursement. To determine if the practice site is outside the 40 mile border, view the zip code table on our website at http://www.dhhs.state.nc.us/dma/Forms/provenroll/zip.pdf.

If you are located outside the North Carolina border and your zip code is not listed in this table please do not complete this application. Visit our website at http://www.dhhs.state.nc.us/dma/provenroll.htm and choose the Dentist Out-of-State or Physician Out-of-State Provider Application and Participation Agreement. Enrollment for out-of-state providers is not open-ended; enrollment is on a claim-by-claim basis for emergency medical services rendered to N.C. Medicaid recipients. Services provided **out-of-state** must be prior approved unless they are for a medical emergency in which the recipient's health would be endangered by returning to North Carolina before receiving treatment. For prior approval of outpatient services, call EDS at 1-800-688-6696 or 919-851-8888. For prior approval of inpatient psychiatric admissions, call ValueOptions at 1-888-510-1150.

In-State Providers

1. **A separate application is required for each Medicaid applicant.**

2. **Provider Name:** _____

3. **The information below must be completed if a provider is operating under DBA or legal business name. A provider doing business under his or her own name/SS# should leave this section blank. (Legal Business Name if applicable.)**
   FEIN#:_____
   ***FEIN Business Name should be consistent with how taxes are filed**.

4. **Enter the street address of the location where services will be rendered. Post office box addresses are not acceptable as physical addresses. If mail cannot be received at the physical address, enter the physical address first and the post office box second.**

_____
Business Site/Physical Address

_____
Box/Suite (if applicable)

_____ _____ _____
City **State** **Zip Code + 4 Digits (**Last 4 digits required**)**

_____ _____
County of Business Site/Physical Address **Business Email Address**

(_____)_____(_____)_____
Area Code Telephone Number **Area Code Fax Number**

5. Enter the address where Medicaid payment information (remittance advice) should be sent. If this item is blank, the remittance advice will be sent to the address in Item 4.

_____

Street Address for payment

_____ _____ _____

City **State** **Zip Code + 4 Digits (**Last 4 digits required**)**

6. Enter the Social Security Number of the individual applicant.
Provider's Social Security Number: _____

Date of Birth (individual provider only):_____/_____/_____
(MM/DD/YYYY)

Gender: Male ☐ Female ☐
Only one may be checked. If you are applying for both an individual number and a group number you must complete a separate application for each:

☐ Individual Physician
☐ Individual Dentist

REQUIRED EFFECTIVE 1/1/2007

7.*National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

***YOU MUST ATTACH A COPY OF YOUR NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM (NPPES) CERTIFICATION LETTER.**

Taxonomy: ☐☐☐☐☐☐☐☐☐X
☐☐☐☐☐☐☐☐☐X
☐☐☐☐☐☐☐☐☐X

Note: To report additional taxonomy, please complete additional taxonomy page.

8. Medical or Dental Board Licensure:
License Number: _____Current Expiration Date: _____

9. Enter the appropriate specialty for your practice:
a. Primary Specialty: _____

Check one: **☐ Board Certified** **☐ Board Eligible**

Certification Date: _____/_____/_____ Certification Number: _____
(MM/DD/YYYY)

b. Secondary Specialty: _____

Check one: ☐ **Board Certified** ☐ **Board Eligible**

Certification Date: _____/_____/_____ **Certification Number:**_____
(MMDDYYYY)

10. Uniform Provider Identification Number (UPIN), if applicable: _____

11. Current DEA number: _____

12. Medicare number: _____

13. Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.

Certification Type: □ **Regular** □ **Waiver** □ **Accreditation**

□ **Partial Accreditation** □ **Registration** □ **PPMP**

CLIA Number: _____

Begin Date: _____/_____/_____ **End Date:** _____/_____/_____

Individual Provider Application

14. Individual Providers Only. Enter the Medicaid provider number(s) assigned to any group practice with which you wish to be affiliated. If you do not want to be affiliated with a group practice, leave this item blank.

a. Group Membership Information

Group Provider Name	Group Provider Number	Group Tax Identification Number

b. Is a group enrollment pending with this application? ☐ **Yes** ☐ **No**

15. Check the appropriate type based on how you as a provider file taxes at the end of the year:

☐ Corporation (LLC, PLLC)

- ☐ Non-Profit Agency
- ☐ Partnership
- ☐ Sole Proprietorship

☐ W-2 Employee

☐ 1099 Contractor

☐ Other (Please explain)

If other, please explain below:

_____

_____

If the provider or provider agency is incorporated, please attach a copy of the Articles of Incorporation. This applies to all corporation types (LLC, PLLC, etc).

16. Please answer all sections (a –e) of this question.

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?

Yes ☐ No ☐

If yes, list the name(s) of the individual(s) and provide a copy of the criminal complaint and final disposition:

_____

_____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?

Yes ☐ No ☐

If yes:

Against Whom? _____
Action Taken? _____
Who Took Action? _____
Date of Action? _____

If yes, please attach a copy of the final disposition. Also attach documentation from the proper authorities approving the reinstatement of the license.

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?

Yes ☐ No ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

Yes ☐ No ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

e. Owed money to Medicaid or Medicare that has not been paid? Yes ☐ No ☐

17. Do you or any individuals, directors, or owners listed in Item 15 have ownership in any other Medicaid enrolled businesses? Yes ☐ No ☐

If yes, list other Medicaid enrolled businesses you own and the names of all owners, with five percent or more ownership of the business. Attach additional pages if necessary.

Name of Owner	Name of Other Business	Provider Number

18. Is this application based on a change of ownership? Yes ☐ No ☐

If yes, give date of ownership change: _____

If yes, give the previous ownership information:

Name Previous Owner	Address of Previous Owner	Medicaid Provider Number	Federal Tax ID

A change of ownership (CHOW) occurs whenever the stock or assets/liabilities of a business are purchased or transferred by the existing owners to new owners. New ownership of a Medicaid provider requires a new provider number. Medicaid provider numbers are not transferable. The following is a list of situations that generally are not considered a change of ownership:

- **Parent corporations absorb or merge with their fully owned sub-corporations;**
- **the owners and structure of the Medicaid enrolled entity remain the same; and**
- **the name of a company changes, but neither the company owners nor the federal tax identification numbers change.-**

Note: A copy of the stock transfer document or bill of sale is required to document a change of ownership.

CERTIFICATION STATEMENT

Complete the signature portion below. The application must contain an original signature and date. Copies and signature stamps are not acceptable. This section also requires the signature and date thereof of an "Authorized official" or delegate official who can legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicaid program. The "Authorized Officials" may delegate granting signature authority to a (Delegated Official) employed by the supplier for the purpose of reporting future changes to the supplier's enrollment record.

By his/her signature(s), the authorized or delegated official named below agree to adhere to the following requirements stated in this Certification Statement:

1) I agree to notify the Medicaid contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.

2) I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this application form, billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.

3) I agree to abide by the laws, regulations, and program instructions that apply to this supplier.

4) Neither the supplier, nor any 5% or greater owner, partner, officer, director, W-2 managing employee, authorized official or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicaid or other Federal program beneficiaries.

5) I agree that any existing or future overpayment made to the supplier by the Medicaid program may be recouped by Medicaid through the withholding of future payments.

6) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

_____ _____

Signature of Applicant **Date**

_____

Typed or Printed Name & Title of Applicant

CONSENT TO RELEASE OF INFORMATION

I understand that the North Carolina Division of Medical Assistance (DMA) is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

A photocopy of this consent shall be as effective as an original when presented.

Provider's Signature: _____

Provider's Printed Name: _____
Date: _____

(Attach additional sheets if necessary)

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
MEDICAID PARTICIPATION AGREEMENT

DMA Provider Services·2501 Mail Service Center·Raleigh, NC 27699-2501·Telephone: 919-855-4050

Individual Provider Name **Telephone Number**

Provider Site Street Address:

City **State** **Zip**

Provider Mailing Street Address:

City **State** **Zip**

1. Parties to the Agreement

This Agreement is entered into by and between the North Carolina Department of Health and Human Services, Division of Medical Assistance, hereinafter referred to as the "Division", and _____, hereinafter referred to as the "Provider."

2. Agreement Document

This Agreement shall consist of this Agreement and the Provider's application, incorporated herein by reference.

3. Governing Law and Venue

This Agreement shall be governed by the laws of the State of North Carolina. In the event of a lawsuit involving this Agreement, venue shall be proper only in Wake County, North Carolina.

The Provider is subject to and shall comply with all federal and state laws, regulations and rules, State Medicaid Plan, and policies, provider manuals, and Medicaid bulletins published by the Division and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

4. License

The Provider shall be licensed, certified, registered, or endorsed as required by State and/or Federal law at all times that services are provided. The Provider will notify the Division within seven (7) days of learning of any adverse action initiated against the license, certification, registration or endorsement of the Provider or any of its officers, agents, or employees. The Provider shall not bill the Division for services rendered during the lapse, for whatever reason, of any required license, certification, registration or endorsement as required by State and/or Federal law.

5. Billing and Payment

The Provider agrees:

a. To submit claims for services rendered to eligible recipients, as identified by the Division, in accordance with rules and billing instructions in effect at the time the service is rendered.
b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the Program, except for payments from legally liable third parties and authorized cost sharing by recipients for goods, services, or supplies provided to a recipient if such are not covered by the Medicaid program. In no event shall the Division be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.
c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to the Division. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.
d. To bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.
e. To not charge the recipient or any other person for items and services covered by the Medicaid Program and to refund payments made by or on behalf of the recipient for any period of time the recipient is Medicaid approved, including dates for which the recipient is retroactively entitled to Medicaid.
f. To accept assignment of Medicare payment in order to receive payment from Medicaid for amounts not covered by Medicare for dually eligible recipients.
g. To refund and allow DMA to recoup any monies received in error or in excess of the amount to which the Provider is entitled from the Medicaid program as soon as the provider becomes aware of said overpayment or within **30** days of request for repayment by the Division, regardless of who caused the overpayment. Causes of overpayment include but are not limited to, lack of documentation for claimed services, improper billing, payments by third parties, failure to supply requested records, failure to disclose ownership interests, failure to disclose persons convicted of crimes associated with medical assistance programs, or failure to disclose sanctioned individuals.
h. That payment for covered services under Medicaid is limited to those services certified as medically necessary in the judgment of a qualified physician or other practitioner of the healing arts, for the proper management, control, or treatment of recipient's medical problem and provided under the physician's or practitioner's direction and supervision.
i. That items or services provided under arrangements or contracts with outside entities and professionals meet professional standards and principles and are provided promptly.
j. That payment and satisfaction of this claim will be from federal, state and county funds, and that any false claims, false statements or documents, or misrepresentation or concealment of a material fact may be prosecuted by under applicable State and/or Federal law.
k. That the Division may withhold payment because of irregularity for whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the Provider and/or the Division and its agents. If the Division withholds payment or is entitled to recovery, such withholding or assessment of recovery may be imposed on any and all provider numbers in which the healthcare provider has an interest or in which he may have an interest.

l. That billings and reports related to services to Medicaid recipients and the cost of that care shall be submitted in the format and frequency specified by the Division and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time-frames established by Division rule or policy may result in suspension of reimbursements and/or other enforcement actions.

m. That no Medicaid payment will be made for claims received by the Division later than twelve months following the date the service was provided, except that any periods of time exceeding thirty days, from the time the Provider requests an authorization to the time the authorization is sent to the Provider, shall be added to the twelve months.

n. To comply with all Health Insurance Portability and Accountability Act requirements.

6. Disclosure

The Provider agrees to submit to the Division professional, business, and personal information concerning the Provider, and any person with an ownership interest in, and any agent of, the Provider, including information as to any violation of regulations of any private insurer or payor. Such information shall include:

(I) Proof of holding a valid license or operating certificate, as applicable, if required by federal or state law or by rule or by a local jurisdiction in which the Provider is located.

(II) Any prior violation, fine, suspension, termination, or other administrative action taken under federal or state law or rule or the laws or rules of any other state relative to medical assistance programs, Medicare, or a regulatory body.

(III) Any prior violation of the rules or regulations of any other public or private insurer.

(IV) Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other health care provider or health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(V) If a group Provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the medical assistance programs.The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement. If the provider is found to be convicted of an offense outlined in paragraph 9, the Division may terminate the provider or deny approval of the application as described in paragraph 9.

At any time during the course of this Agreement, the Provider agrees to notify the Division of any material and/or substantial changes in information contained in the enrollment application given to the Division by the Provider. This notification must be made in writing within thirty (30) days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

a.ownership;
b.licensure;
c.federal tax identification number;
d.additions, deletions, or replacements in group membership; and
e.any change in address or telephone number.

7. Inspection; Maintenance of Records; Filing Reports

For five years from the date of services, or longer if required specifically by law or post payment audits, the Provider shall:

a. Keep, maintain and make available complete and accurate medical and fiscal records in accordance with generally accepted accounting principles and Medicaid record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Division. For providers who are required to submit annual cost reports, fiscal records may include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Division law or policy.
b. Furnish upon request appropriate documentation, including recipient records, supporting material, and any information regarding payments claimed by the Provider, whether in the possession of contractors, agents, or subcontractors, for review by the Division, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office and/or other entities as required by law. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Division may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program.
c. Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Program. If the provider is notified that an audit or investigation is has been initiated, the Provider shall retain all original records and supportive materials until the audit or investigation is completed and all issues are resolved even if the period of retention extends beyond the required 5-year period.
d. Federal and State officials and their agents may make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to Medicaid recipients. Such visits must be allowed at any time during hours of operation, including unannounced visits. Failure to allow such visits or grant immediate access upon reasonable request may result in suspension of reimbursements. .

8. Division Responsibilities

The Division shall:
a. Make timely payment at the established rate for services or goods furnished to a recipient by the provider in accordance with the policy in effect at the time the services are rendered.
b. Not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the State's determination of eligibility of a recipient.
c. Enroll a provider in the Medicaid program if the provider has
    1) submitted an application, licensure, and other supporting documentation;
    2) agreed to the terms of this Agreement; and
    3) otherwise complies with the requirements for enrollment. Once approved, the Division will issue a unique Medicaid provider number to the provider.
d. Furnish to Provider, upon enrollment and on request thereafter, a current copy of the appropriate provider manuals. Current provider manuals, policy and bulletins will be available on the North Carolina Division of Medical Assistance website. Copies will also be available on request.

9. Termination

Either the Division or the Provider may terminate this agreement with or without cause at any time upon 30 days written notification to the other. The Division may summarily terminate without giving 30 days written notice under the following circumstances:

a. The Provider fails to meet conditions for participation, including licensure, certification, endorsement or other terms and conditions stated in this Agreement, or
b. The Provider is determined to have violated Medicaid rules or regulations, or
c. the Provider has been convicted of a criminal offense related to the delivery of an item or service under Title XVIII or under any State health care program, or
d. the Provider has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care items or service, or
e. the Provider has been convicted of an offense under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
f. Any person with ownership or control interest in the Provider or an agent or managing employee of the Provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or
g. The Provider fails to provide medically appropriate health care services, or
h. The Division determines it to be in the best interests of the Medicaid Program and/or the
i. Medicaid recipients to do so.

10. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

11. Confidentiality

The Provider shall not use or disclose information concerning Medicaid recipients, except as provided in paragraph 7 above, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the Provider, establishing eligibility of the recipient, and billing for services of the Provider. Neither recipient records nor portions thereof may be transferred except by written consent of the recipient or as otherwise provided by law.

12. Indemnification and Hold Harmless

The Provider agrees to indemnify and hold harmless the Division, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Provider or any subcontractor.

13. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

14. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Division.

15. Availability of Funds

The parties to this Agreement understand and agree that the payment of the sums specified in this Agreement is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Division.

16. Discrimination

The parties agree that the Division may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with the Division; who is performing services or supplying goods in accordance with federal, state and local law; and who agrees to provide services to Medicaid eligible recipients of the same quality as are provided to private paying individuals and without regard to race, color, age, sex, religion, disability, or national origin.

17. Agreement Retention

The parties agree that the Division may only retain the signature page of this agreement, and that a copy of the standard provider agreement will be maintained by the Director of the Division, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

18. Electronic Claims Submission

I have read the conditions for submission of electronic claims contained in the enclosed Electronic Claims Agreement and hereby elect to:

☐ Submit claims electronically and to abide by the conditions for electronic submission.

☐ Not submit claims electronically at this time.

I understand that a separate agreement for electronic claims must be signed and approved if I elect to file claims electronically.

SIGNATURE OF PROVIDER:

By: _____

Signature of Applicant **Date**

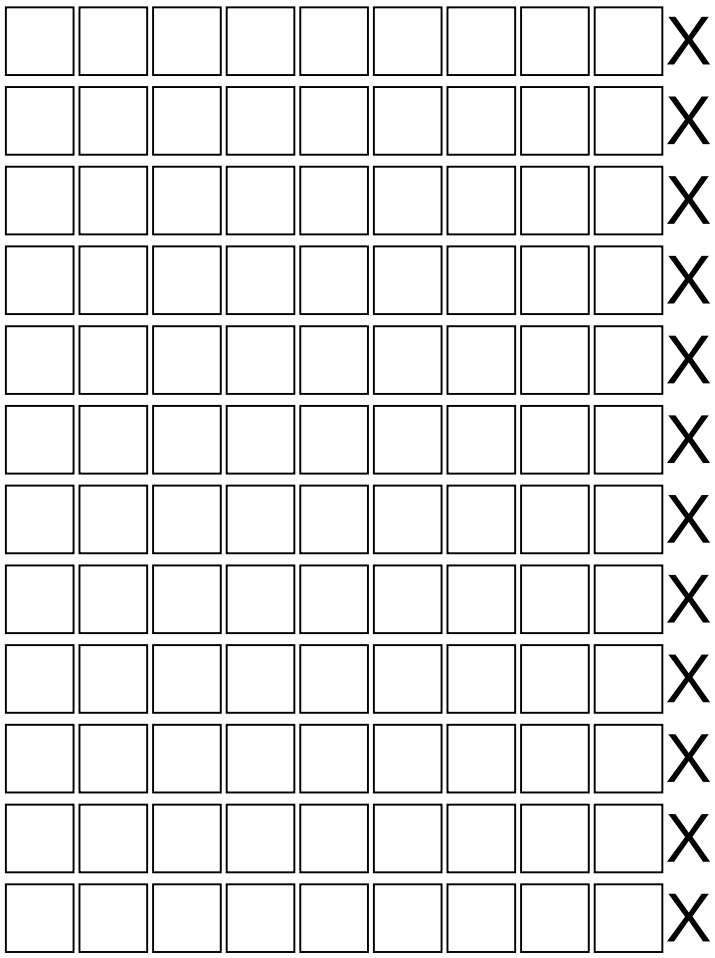
_____

Typed Name and Title of Applicant

_____

Name of Corporation **IRS Number**

Additional Taxonomy:



NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION

FOR

SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

Group **or** attending provider number to which this certification applies:_____

(Leave blank if submitting with new enrollment packet. A provider number will be assigned once enrollment is complete. This certification is only applicable to the provider number listed above. When the attending number is required on a claim form, each attending provider is required to fill out a separate certification in addition to the group certification.)

_____

Provider Name (must exactly match name on application)

Signature of Provider Listed Above or Authorized Agent (Authorized Agent only applicable for group provider numbers) Date

Mail completed form to:
(Must be original, faxes not accepted)

DMA-Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
INSTRUCTIONS FOR COMPLETING THE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

Carefully read the ECS Agreement in its entirety. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims. The ECS Agreement is not transferable from one group practice to another, from one owner of a practice/facility to another or for members of a group moving to another group or solo practice. The Agreement may not be altered or marked in any way. Photo or fax copies are not accepted. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

1. Type or print in black ink and **return all copies** to the **Division of Medical Assistance**. Do not separate the copies.

2. Upon DMA approval, a signed copy will be returned to the provider. **Claims should not be submitted electronically until there is an approved ECS Agreement and transmission has been tested with EDS (DMA's fiscal agent).**

3. Provider Business Name
   a. Enter the name of the business/practice/facility or the name of the practitioner if the business is a solo practice.
   b. If you are currently enrolled in the N.C. Medicaid program, the provider name entered on the Agreement must match the name on the Remittance and Status Report.
   c. If the name of the business/practice/facility has changed since enrollment, attach an explanation or call the DMA Provider Services Unit at 919-855-4050.

4. Mailing Address – Enter the address for receipt of mail if different from the site address. If either address has changed and DMA has not been notified, please attach an explanation. If the addresses on the Agreement do not match those in DMA's provider files, the ECS Agreement will be returned.

5. Signature – Original signatures are required. Signature stamps are not acceptable.
   a. The signature of the provider is required for solo practitioners and partnerships.
   b. The owner, business officer or an individual who has authority to enter into contracts on behalf of the provider organization must sign the Agreement.
   c. An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign for the group.
   d. When new members join a group that **already has an ECS Agreement**, simply complete page three and **add the new providers' signatures only**. Current providers do not have to sign the Agreement again.

6. Provider Number – List the number to which Medicaid payment is to be made.

7. Completion of the bottom section on page three is required if filing under a group provider number, even if there is only one practitioner in the group.

8. Before submitting electronic claims, contact the ECS unit at EDS, 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) Electronic claims will not process until EDS activates authorization for ECS billing. The ECS Unit must assign an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to:

Provider Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

DMA Provider Enrollment, 2501 Mail Service Center Raleigh, NC 27699-2501

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents. Provider will

7. keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.

16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

The undersigned having read this Agreement for billing Medicaid claims electronically and understanding it in its entirety, hereby agree(s) to all of the stipulations, conditions, and terms stated herein.

Individual Provider Name: _____

Medicaid Attending Number (if currently enrolled): _____

Business Site/Physical Address:

_____

Street

_____

City & State **Zip Code + Four (Last 4 digits required)**

_____

Signature of Individual Provider **Date**

_____

Typed or Printed Name and Title of Individual Provider

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
| | | | - | | - | | | | |

or

Employer identification number
| | | - | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

DMA USE ONLY

EFFECTIVE DATE

This agreement is effective _____, subject to renewal on a periodic basis, or execution of a new agreement when DMA determines that changes in law, Medicaid regulation or policies or other material circumstances so require or by act of the parties as herein provided, or by operation of law.

DMA APPROVAL

Accepted on _____ by _____

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

WE WILL NOT BE ABLE TO COMPLY IF US POSTAGE IS NOT AFFIXED.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services